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	17E613	A. BUILDING _____ B. WING _____	C 08/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOGAN COUNTY MANOR - LTCU	615 PRICE AVE OAKLEY, KS 67748

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F 000	INITIAL COMMENTS The following citations represent the findings of complaint investigation #89459. A revised copy of the 2567 was sent to the provider on 8/14/15.	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated	F 225		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

This REQUIREMENT is not met as evidenced by:
The facility had a census of 35 residents. The sample included 3 residents. Based on observation, interview, and record review the facility failed to thoroughly investigate and report, to the local state agency a choking episode for 1 of 3 sampled residents. The incident resulted in a visitor performing the Heimlich maneuver (first-aid procedure for dislodging an obstruction from a person's windpipe in which a sudden strong pressure is applied on the abdomen, between the navel and the rib cage). (#2)

Findings included:

- Resident #2's admission (MDS) Minimum Data Set assessment, dated 5/4/15, indicated the resident had moderate cognitive impairment with a (BIMS) Brief Interview for Mental Status score of 10, and was independent with (ADLs) Activities of Daily Living, including eating.

The 5/13/15 care plan indicated the resident independent with ADLs.

The 4/29/15 physician's order directed staff to provide a regular diet to the resident.

The 5/22/15 at 11:50 AM, nurse's note indicated the resident, while seated at the dining room table

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eating his/her noon meal, choked on a piece of meat. The note further indicated a visiting family member performed the Heimlich maneuver on the resident x 3 and dislodged the meat. The note indicated the nurse witnessed the maneuver after he/she heard another resident yelling for help.

The 5/22/15 at 12:10 PM, nurse's note indicated the resident was lying in bed, in his/her room, and did not want to continue to eat lunch. The note further indicated the nurse notified the (DON) Director of Nursing about the incident.

On 8/5/15 at 12:00 PM, observation revealed the resident seated in the dining room, eating his/her noon meal. Continued observation revealed the resident had received ground meat, and had no problems independently eating the meal.

On 8/6/15 at 7:30 AM, continuous observation of the morning meal revealed 7-8 residents seated in the dining room eating breakfast. Further observation revealed multiple staff in and out of the dining room, and multiple times leaving the residents alone for 2-5 minutes in the dining room without supervision.

On 8/6/15 at 8:45 AM, Nurse B verified he/she was in the dining room on the day the resident had choked. Nurse B stated he/she heard another resident state this resident was choking, and when he/she got to the resident a family member successfully administered the Heimlich, and stopped the resident's choking episode. Nurse B stated staff were present at the time, but the family member had gotten there first, and had it under control. Nurse B verified, due to call lights and returning residents to their rooms, there are times residents are left alone in the dining room.

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F 225	Continued From page 3 On 8/6/15 at 10:53 AM, Nurse Aide C verified there are times, especially during the morning meal, staff are not in the dining room with the residents while they are eating. On 8/6/15 at 1:45 PM, Administrative Staff A verified the facility did not complete an investigation, or report the incident to the state. Administrative Staff A verified the facility should have notified the state agency regarding the resident's choking incident. The facility's, 3/2012, Abuse, Neglect, Exploitation policy instructed staff to notify the appropriate authorities when an incident occurred and to complete a thorough investigation within 5 days. The facility failed to thoroughly investigate and report an incident of choking for Resident #2, to ensure an environment free of abuse and neglect.	F 225		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are	F 279		

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to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).

This REQUIREMENT is not met as evidenced by:
The facility had a census of 35 residents. The sample included 3 residents, which were reviewed for behaviors. Based on observation, interview, and record review the facility failed to develop a comprehensive plan of care to instruct staff how to manage increasing behaviors of 1 of 3 residents reviewed for behavior management. (#1)

Findings included:

- Resident #1's medical record revealed the facility admitted the resident on 7/17/15.

The resident's 7/18/15 initial care plan revealed no instruction to the staff for interventions regarding the resident's behaviors.

The 7/17/15 admission physician ordered instructed staff to administer the following to the resident:
- Exelon Patch (an acetylcholinesterase inhibitor to treat Alzheimer's disease), 9.5 (mg) milligrams, daily, for senile dementia
- Namenda XR (a NMDA receptor antagonist to treat Alzheimer's disease), daily, for senile dementia

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The 7/18/15 4:34 PM, nurse's note indicated the resident required 1-2 person assist with cares, and has been incontinent of urine several times throughout the day. The note indicated the resident voided on the floor in the hall by the soda machine, got his/her clothes all wet, and was uncooperative with allowing the staff to provide care. The note indicated the resident became angry and yelled at staff. The note further indicated the resident wandered into other resident rooms, would lie down on his/her roommates' bed when tired, and at times tried to sit down when there was no chair.

The 7/18/15 at 9:29 PM, nurse's note indicated the resident had difficulty taking medication due to confusion and required a lot of cueing.

The 7/19/15 at 7:30 AM, nurse's note indicated 2 staff assisted the resident, who was uncooperative to get dressed, and would not follow verbal commands. The note indicated the resident cussed at staff and pulled off his/her socks as staff attempted to put on his/her shoes.

The 7/20/15 at 6:40 AM, nurse's note indicated staff attempted to assist the resident with toileting and the resident got close to the staff's face, and started cussing.

The 7/20/15 physician's order instructed staff to administer Seroquel (an antipsychotic), 25 mg, three times daily, for dementia.

The 7/23/15 physician's order instructed staff to administer Seroquel, 100 mg, every evening, for dementia with behavioral disturbances, to the resident.

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The 7/28/15 at 4:19 AM, nurse's note indicated staff found the resident in another resident room, and redirected his/her to him/her own room.

The 7/30/15 at 10:20 AM, nurse's note indicated staff noted the resident was fumbling with his/her zipper, asked the resident if he/she needed to use the toilet, and the resident was unable to comprehend. The note indicated when trying to get the resident to sit, he/she became agitated, and shook his/her left fist at staff.

The 8/1/15 at 10:30 AM, nurse's note indicated the resident yelled and cussed at staff during cares.

The 8/4/15 at 5:22 PM, nurse's note indicated staff attempted to toilet the resident and he/she refused and cussed at staff.

The 8/5/15 at 11:00 AM, nurse's note indicated the resident ambulated in the halls, incontinent of urine, and would not allow staff to assist with cares. The note further indicated at 11:10 AM, the resident's family member arrived and was unable to get the resident to calm down. The note indicated the resident cussed and yelled at the family member who requested a sedative for the resident. At 11:15 AM, the note indicated staff received a physician's order to change the resident's Seroquel, and to administer Haldol. At 11:35 AM, the note indicated the resident was walking in the back yard with a family member, and at 11:50 AM ate his/her noon meal. At 12:50 PM, the note indicated the family informed staff the resident was irritable and crabby and wanted the Haldol administered. At 12:55 PM, the note indicated staff administered the Haldol to the

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resident.

The 8/5/15 physician's order instructed staff to administer Seroquel, 50 mg, three times daily, for dementia with behaviors, to the resident.

On 8/5/15 at 1:24 PM, observation revealed the resident, seated on his/her bed in a seated position, leaned over to the left, with his/her eyes closed and feet dangling.

On 8/5/15 at 2:45 PM, observation revealed the resident lying in a different bed in his/her room, with his/her body completely on the bed, and his/her eyes closed.

On 8/5/15 at 4:33 PM, observation revealed the resident seated on the side of his/her bed, rubbing his/her face and looking around the room. Further observation revealed the resident attempted to stand, but failed and continued in a seated position. Continued observation revealed the resident stood at the side of the bed, walked to the other side of the room, then came back to the bed, laid down, and closed his/her eyes.

On 8/5/15 at 1:45 PM, Administrative Nurse E verified he/she had not developed a comprehensive care plan to guide the staff to manage the resident's behaviors.

On 8/5/15 at 2:38 PM, Nurse Aide G stated he/she can not get the resident to do simple things, such as sit down. Nurse Aide G stated he/she does not feel adequately trained to care for the resident, manage the resident's behaviors, and does not have the staff or ability to care for him/her.

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F 279	Continued From page 8 On 8/5/15 at 2:52 PM, Nurse D verified the resident's behaviors are hard to manage. Nurse D stated staff have to approach the resident softly, with direct commands, and some of the staff don't feel comfortable taking care of the resident because they do not know how to approach the resident. On 8/6/15 at 10:40 AM, Nurse Aide J stated the resident is verbally and physically abusive, and he/she is afraid of the resident. Nurse Aide J stated he/she does not think the facility is equipped to care for him/her as the facility is always busy, and it aggravates him/her. On 8/6/15 at 10:57 AM, Nurse Aide I verified the resident displays aggressive behavior, says a lot of cuss words, and sometimes can be scary. On 8/6/15 at 1:22 PM, Administrative Nurse E verified the resident was not interviewed before being admitted into the facility, and staff are now starting to learn some things to help manage his/her behavior. The facility failed to develop a comprehensive plan of care to provide staff guidance with managing Resident #1's behaviors.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed	F 280		

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within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

This REQUIREMENT is not met as evidenced by:
The facility had a census of 35 residents. The sample included 3 residents, reviewed for behaviors. Based on interview, and record review the facility failed to review and revise 1 of 3 resident's care plan to adequately instruct staff how to effectively manage increased behaviors. (#3)

Findings included:

- Resident #3's physician order sheet, dated 7/7/15, indicated the following diagnosis: delusional disorder (untrue persistent belief or perception held by a person although evidence shows it was untrue), hallucinations (sensing things while awake that appear to be real, but the mind created), suicidal ideation (thinking about, considering, or planning suicide), major depressive disorder (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness and hopelessness), anxiety (mental or emotional

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reaction characterized by apprehension, uncertainty and irrational fear), and dementia (progressive mental disorder characterized by failing memory, confusion).

The quarterly (MDS) Minimum Data Set assessment, dated 6/29/15, indicated moderate cognitive impairment with a (BIMS) Brief Interview score for mental status score of 12, and exhibited inattention, delusion, verbal behaviors directed toward others, and wandering behaviors.

The 7/8/15 care plan informed staff the resident had an alteration in cognitive status with increased confusion, judgement, and poor short and long term memory. The care plan instructed staff to speak to the resident slowly, assess for understanding, and to repeat as needed. The care further instructed staff to anticipate the resident's needs, to take him/her by the hand and lead him/her to what he/she needed to do, and to talk nicely to the resident. The care plan informed staff the resident would do things he/she was told to do. The care plan informed staff the resident went to a behavior unit on 6/5/15, and returned on 6/23/15 with new medications. The care plan instructed staff to encourage the resident to slow down, look at him/her in the face, and not to "gang up" on him/her.

The 7/6/15 psychotherapy progress note indicated the resident presented with anxiety, chronic pain, agitation, delusions, suicidal ideation, and alcoholism. The note indicated therapeutic intervention was going to where the resident was in his/her delusions, and progress toward treatment if he/she failed to comprehend the court process, and continued to obsess about his/her money.

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The 7/8/15 at 3:53 PM, nurse's note indicated the resident stated he/she felt like rigor mortis (is one of the recognizable signs of death, caused by chemical changes in the muscles after death, causing the limbs of the corpse to stiffen after death) was setting in, and then laughed.

The 7/13/15 psychotherapy progress note indicated the resident remained obsessive and delusional.

The 7/13/15 at 9:00 PM, nurse's note indicated staff could not locate the resident during 15 minute checks. The note further indicated staff found the resident in another resident's room, sleeping in a chair. The note indicated staff redirected the resident back to his/her room, and he/she had increased weakness.

The 7/15/15 at 2:41 PM, nurse's note indicated the resident wandered up and down halls throughout the day, asked another resident to take him/her to the bank, and would get upset with him/herself for forgetting things.

The 7/21/15 at 9:06 AM, nurse's note indicated the resident followed the housekeeper around, and attempted to follow staff into the laundry/ kitchen area. The note further indicated staff reminded the resident that area was only for staff, and encouraged the resident to lie down. The note indicated the resident continued to ambulate in the halls.

The 7/21/15 at 9:45 AM, nurse's note indicated staff noted the resident had edema (swelling) to his/her lower extremities, and staff encouraged the resident to sit in his/her recliner with feet up.

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The note indicated the resident stated, "I can't because the FBI is after me, and if they get hold of me it won't be good".

The 7/21/15 at 1:55 PM, nurse's note indicated the resident had aggressive behavior, and pushed the housekeeping cart into the housekeeper while in hallway near the resident's room. The note further indicated staff encouraged the resident to sit in his/her wheelchair, was assisted to his/her room, and staff administered pain medication. The note indicated the staff went to assist other residents to get up, and the resident was attempting to get the other residents up with the staff. The note further indicated staff encouraged the resident to go back to his own room, as they did not need help. The note indicated the resident heard a knock on the door, went through the bathroom back to his/her room, and thought the FBI was knocking on the door looking for him/her.

The 7/21/15 at 10:30 PM, nurse's note indicated staff found the resident in the cosmetology room, seated on a chair, with his/her pants down. The note indicated staff asked the resident if he/she needed to use the bathroom, and the resident stated he/she was on the toilet, and needed a minute. The note indicated staff informed the resident it was not the bathroom, and the resident stated he/she gets mixed up sometimes.

The 7/21/15 fax to the physician informed the physician of the resident's increased behaviors.

The 7/22/15 at 8:15 AM, nurse's note indicated staff redirected the resident from trying to go outside to get his/her vehicle, by reminding him/her there was no vehicle outside.

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The 7/23/15 physician's order instructed staff to obtain blood laboratory ammonia level, administer Lasix (a diuretic), 40 (mg) milligrams, every morning, and to obtain a basic metabolic profile blood laboratory test in 1 week.

The 7/24/14 at 2:19 AM, nurse's note indicated staff found the resident in another resident's room, and administered an Ativan injection due to restlessness and anxiety.

The 7/24/15 at 3:58 AM, nurse's note indicated staff located the resident in another resident's room and redirected him/her to the dining room.

The 7/24/15 at 8:24 AM, nurse's note indicated the resident pushed a door and set off the alarm to the courtyard door.

The 7/24/15 at 8:50 AM, nurse's note indicated staff observed the resident enter another resident's room, turn on the light, and nursing staff redirected the resident to the dining room.

The 7/28/15 at 6:00 PM, nurse's note indicated staff transferred the resident to a geriatric psych hospital.

On 8/5/15 at 2:38 PM, Nurse Aide G stated the resident was delusional and thought everyone was out to get him/her, like the FBI. Nurse Aide G verified the resident was in other resident's rooms, would pack up his/her roommates belongings, and had thrown his roommate's supper in the trash. Nurse Aide G stated staff would try to redirect the resident, or distract him/her, and it didn't matter how staff would try to distract him/her because he/she was always on

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F 280	Continued From page 14 some kind of kick. On 8/6/15 at 8:11 AM, Nurse B verified the resident constantly went into other resident rooms, would get confused, agitated, and would not believe what staff would tell him/her. On 8/6/15 at 9:20 AM, Nurse Aide H stated there were moments when the resident would be normal and enjoyable, but you did not know from one moment to the next if he/she would start stacking things, or hurt other frail elderly residents. Nurse Aide H stated the resident had strength, but no brains, and would get loud, cuss, which offend and scare the other residents. Nurse Aide H stated when the resident was being helpful he/she would put other residents in their wheelchair, lay on their beds, and it would scare them. Nurse Aide H further stated the facility is staffed for people who require nursing care, not care for mental illness. On 8/6/15 at 10:33 AM, Nurse Aide F stated staff performed 15 minute checks on the resident to make sure he/she was not in trouble and safe. On 8/6/15 at 1:45 PM, Administrative Nurse E verified the resident's care plan was not updated with adequate direction to the staff to manage the resident's behaviors appropriately. The facility failed to review and revise Resident #3's care plan to effectively manage behaviors.	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain	F 309		

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or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

This REQUIREMENT is not met as evidenced by:
The facility had a census of 35 residents. The sample included 3 residents, which were reviewed for behaviors. Based on observation, interview, and record review the facility failed to provide care and services to adequately manage behaviors for 1 of 3 sampled residents. (#1)

Findings included:

- Resident #1's medical record revealed the facility admitted the resident on 7/17/15.

The resident's 7/18/15 initial care plan revealed no instruction to the staff for interventions regarding the resident's behaviors.

The 7/17/15 admission physician orders instructed staff to administer the following to the resident:
- Exelon Patch (an acetylcholinesterase inhibitor to treat Alzheimer's disease), 9.5 (mg) milligrams, daily, for senile dementia
- Namenda XR (a NMDA receptor antagonist to treat Alzheimer's disease), daily, for senile dementia

The 7/18/15 4:34 PM, nurse's note indicated the resident required 1-2 person assist with cares, and has been incontinent of urine several times throughout the day. The note indicated the

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resident voided on the floor in the hall by the soda machine, got his/her clothes all wet, and was uncooperative with allowing the staff to provide care. The note indicated the resident became angry and yelled at staff. The note further indicated the resident wandered into other resident rooms, would lie down on his/her roommates bed when tired, and at times tried to sit down when there was no chair.

The 7/18/15 at 9:29 PM, nurse's note indicated the resident had difficulty taking medication due to confusion and required a lot of cueing.

The 7/19/15 at 7:30 AM, nurse's note indicated 2 staff assisted the resident, who was uncooperative to get dressed, and would not follow verbal commands. The note indicated the resident cussed at staff and pulled off his/her socks as staff attempted to put on him/her shoes.

The 7/20/15 at 6:40 AM, nurse's note indicated staff attempted to assist the resident with toileting and the resident got close to the staff's face, and started cussing.

The 7/20/15 physician's order instructed staff to administer Seroquel (an antipsychotic), 25 mg, three times daily, for dementia.

The 7/23/15 physician's order instructed staff to administer Seroquel, 100 mg, every evening, for dementia with behavioral disturbances, to the resident.

The 7/28/15 at 4:19 AM, nurse's note indicated staff found the resident in another resident room, and redirected his/her to his/her own room.

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The 7/30/15 at 10:20 AM, nurse's note indicated staff noted the resident was fumbling with his/her zipper, asked the resident if he/she needed to use the toilet, and the resident was unable to comprehend. The note indicated when trying to get the resident to sit, he/she became agitated, and shook his/her left fist at staff.

The 8/1/15 at 10:30 AM, nurse's note indicated the resident yelled and cussed at staff during cares.

The 8/4/15 at 5:22 PM, nurse's note indicated staff attempted to toilet the resident and he/she refused and cussed at staff.

The 8/5/15 at 11:00 AM, nurse's note indicated the resident ambulated in the halls, incontinent of urine, and would not allow staff to assist with cares. The note further indicated at 11:10 AM, the resident's family member arrived and was unable to get the resident to calm down. The note indicated the resident cussed and yelled at the family member who requested a sedative for the resident. At 11:15 AM, the note indicated staff received a physician's order to change the resident's Seroquel, and to administer Haldol. At 11:35 AM, the note indicated the resident was walking in the backyard with a family member, and at 11:50 AM ate his/her noon meal. At 12:50 PM, the note indicated the family informed staff the resident was irritable and crabby and wanted the Haldol administered. At 12:55 PM, the note indicated staff administered the Haldol to the resident.

The 8/5/15 physician's order instructed staff to administer Seroquel, 50 mg, three times daily, for dementia with behaviors, to the resident.

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On 8/5/15 at 1:24 PM, observation revealed the resident, seated on his/her bed, leaning over to the left, with his/her eyes closed and feet dangling.

On 8/5/15 at 2:45 PM, observation revealed the resident lying in a different bed in his/her room, with his/her body completely on the bed, and his/her eyes closed.

On 8/5/15 at 4:33 PM, observation revealed the resident seated on the side of his/her bed, rubbing his/her face and looking around the room. Further observation revealed the resident attempted to stand, but failed and continued in a seated position. Continued observation revealed the resident stood at the side of the bed, walked to the other side of the room, then came back to the bed, laid down, and closed his/her eyes.

On 8/5/15 at 1:45 PM, Administrative Nurse E verified he/she had not developed a comprehensive care plan to guide the staff to manage the resident's behaviors.

On 8/5/15 at 2:38 PM, Nurse Aide G stated he/she can not get the resident to do simple things, such as sit down. Nurse Aide G stated he/she does not feel adequately trained to care for the resident, manage the resident's behaviors, and the facility does not have the staff or ability to care for him/her.

On 8/5/15 at 2:52 PM, Nurse D verified the resident's behaviors are hard to manage. Nurse D stated staff have to approach the resident softly, with direct commands, and some of the staff don't feel comfortable taking care of the

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F 309	Continued From page 19 resident because they do not know how to approach him/her. On 8/6/15 at 10:40 AM, Nurse Aide J stated the resident is verbally and physically abusive, and he/she is afraid of the resident. Nurse Aide J stated he/she does not think the facility is equipped to care for the resident as the facility is always busy, and it aggravates the resident. On 8/6/15 at 10:57 AM, Nurse Aide I verified the resident displays aggressive behavior, says a lot of cuss words, and sometimes can be scary. On 8/6/15 at 1:22 PM, Administrative Nurse E verified the resident was not interviewed before being admitted into the facility, and staff are now starting to learn some things to help manage his/her behavior. The facility failed to adequately implement interventions to manage Resident #1's behaviors.	F 309		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility had a census of 35 residents. The sample included 3 residents. Based on	F 323		

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F 323	Continued From page 20 observation, interview, and record review the facility failed to provide adequate supervision during meal time in 1 of 1 dining room. Findings included: - On 8/6/15 at 7:25 AM, observation revealed 7-8 residents seated in the dining room eating the morning meal. Continued observation revealed staff left the residents unattended in the dining room, several times throughout the meal service, for 2-5 minutes at a time. On 8/6/15 at 8:11 AM, Nurse B verified there are times when staff are not in the dining room while residents are eating. Nurse B stated call lights are going off, and residents want to go back to their rooms. On 8/6/15 at 9:20 AM, Nurse Aide H stated when staff are getting residents up and into the dining room, or back into their rooms after meals, sometimes there is no staff in the dining room with the residents. On 8/6/15 at 1:22 PM, Administrative Staff A verified staff should be in the dining room at all times when the residents are eating, otherwise it could be a safety concern. The facility failed to provide adequate supervision during meal times in 1 of 1 dining rooms.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including	F 329		

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duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.

Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.

This REQUIREMENT is not met as evidenced by:
The facility had a census of 35 residents. The sample included 3 residents, which were reviewed for unnecessary medications. Based on observation, interview, and record review the facility failed to prevent unnecessary medications for 1 of 3 residents who received antipsychotic medications with a contraindicated diagnosis of dementia. (#1)

Findings included:

- Resident #1's medical record revealed the facility admitted the resident on 7/17/15.

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The 7/17/15 at 10:25 AM, admission nurse's note indicated the facility admitted the resident for respite care. The note stated the resident ambulated with a slow, steady, shuffled gait, and was able to perform his/her (ADLs) Activities for Daily Living independently. The note indicated the resident was intermitenly confused, the family reported he/she had no abnormal behaviors, and the resident had no history of wandering.

The resident's 7/18/15 admission care plan failed to include instruction to the staff for the resident's behaviors and antipsychotic medication management.

The 7/20/15 physician's order instructed staff to administer Seroquel (an antipshychotic), 25 (mg) milligrams, three times daily, to the resident for dementia.

The 7/23/15 physician's history and physical indicated the resident has advanced Alzheimer's disease, and behavioral changes with the dementia.

The 7/23/15 physician's order instructed staff to administer Seroquel, 100 mg, every evening, to the resident, for dementia with behavioral disturbances, and to discontinue the 7/20/15 Seroquel order.

The 8/5/15 physician's order instructed staff to administer Seroquel 50 mg, three times daily, to the resident for dementia with behaviors. The physician discontinued the 7/23/15 Seroquel order. The physician's order further instructed staff to administer Haldol (an antipsychotic), 2.5 mg, by intramuscularly injection, x 1 today, to the resident for dementia with behaviors.

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The 8/5/15 at 11:00 AM, nurse's note indicated the resident ambulated in the halls, was incontinent of urine, and would not allow staff to assist with cares. The note further indicated at 11:10 AM, the resident's family member arrived and was unable to calm the resident down. The note indicated the resident was cussing and yelling at the family member and the family requested a sedative for the resident. At 11:15 AM, the note indicated staff received a physician's order to change the resident's Seroquel dose, and to administer Haldol. At 11:35 AM, the note indicated the resident was walking in the backyard with a family member, and at 11:50 AM, ate his/her noon meal. At 12:50 PM, the note indicated the family informed staff the resident was irritable and wanted the Haldol administered. At 12:55 PM, the note indicated staff administered the Haldol to the resident.

On 8/5/15 at 1:24 PM, observation revealed the resident, seated on his/her bed, leaning over to the left, with his/her eyes closed and feet dangling.

On 8/5/15 at 2:45 PM, observation revealed the resident, lying in another unoccupied bed in his/her room, with his/her body completely on the bed, and his/her eyes closed.

On 8/5/15 at 4:33 PM, observation revealed the resident seated on the side of his/her bed, rubbing his/her face and looking around the room. Further observation revealed the resident attempted to stand, but failed and continued in a seated position. Continued observation revealed the resident stood at the side of the bed, walked to the other side of the room, then came back to

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the bed, laid down, and closed his/her eyes.

On 8/5/15 at 2:52 PM, Nurse D verified he/she had administered the Haldol injection to the resident, after he/she had calmed down. Nurse D further verified the resident remained "crabby", and his/her family wanted the medication administered, even though his/her behaviors had resolved, other then being "crabby".

On 8/6/15 at 1:45 PM, Administrative Nurse verified the resident had a contraindicated diagnosisof dementia for the use of Seroquel.

The 2005 drug label located on the (FDA) Food and Drug Administration website indicated Haldol was not approved for the treatment of a patient with dementia-related psychosis. The label further indicated Haldol had a boxed warning that stated elderly patient with dementia related psychosis treated with antipsychotic drugs had an increased risk of death.

The 8/14/08 drug label located on the FDA web site indicated Seroquel was not approved for the treatment of a patient with dementia-related psychosis. The label further indicated Seroquel had a boxed warning that stated elderly patients with dementia related psychosis treated with antipsychotic drugs had an increased risk of death.

The facility failed to provide an environment free from unnecessary medications by administering Seroquel to Resident #1 for a contraindicated diagnosis of dementia.